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PhotoDermDiagnosis
A perianal skin-coloured verrucous plaque in a 35-year-old female

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A 35-year-old woman, married with six children was referred to the dermatology clinic of Aleppo University Hospital, Syria with the chief complaint of erythematous painless papule around anus for 5-month. It gradually enlarged into a skin-colored (3x4 cm) verrucous plaque with some erosions without bleeding (**Figure 1**). There was history of pruritus and discharge in that area. These lesions were clinically consistent with condyloma acuminata. Rest of the history was insignificant except her father and brother had leukemia. General physical examination was normal with no evidence of systemic disease. Serologic testing for viral hepatitis and syphilis was negative. Histological examination of the plaque, showed full thickness keratinocyte dysplasia, with marked nuclear atypia and numerous mitotic figures (**Figures 2** and **3**). Immunohistopathology for HPV was negative.

Figure 1 Verrucous plaque in perianal region.

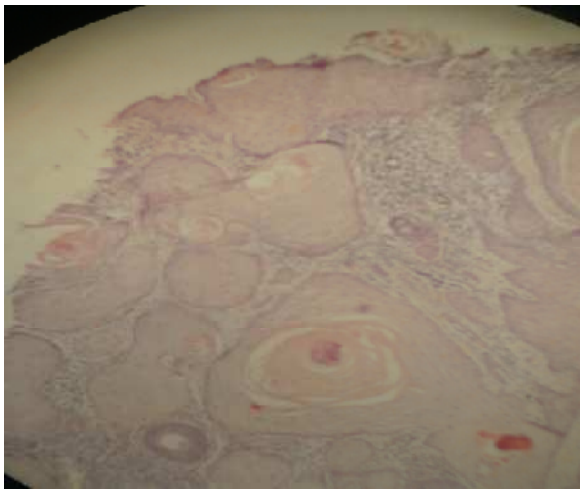
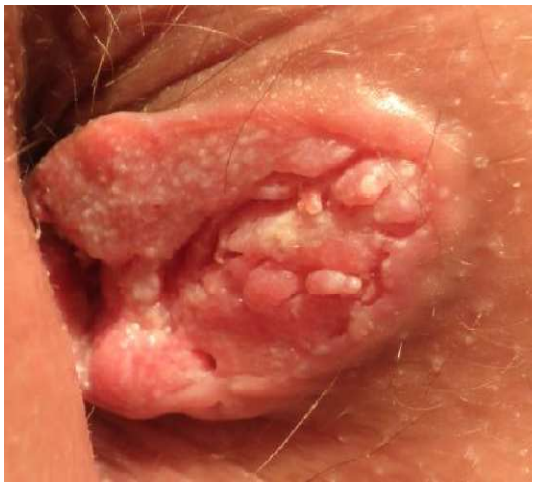


Figure 2 10X magnification.)



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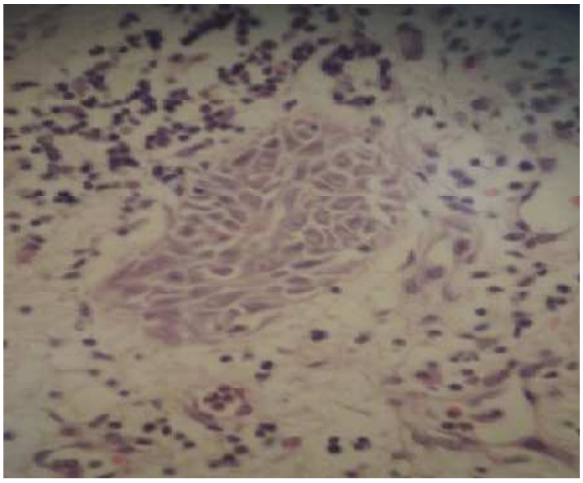

Figure 3 40X magnification.

What is your diagnosis?

Diagnosis

Perianal SCC without evidence of HPV.

Discussion

SCC of the skin is a classic cancer, as it has precursor lesions, tumor progression and the potential to develop metastatic disease. SCC can develop in different regions of the skin, as well as, other sites lined by squamous epithelia, e.g. mouth, esophagus and vagina. SCCs arising on the genitalia and perianal area are also more aggressive with a higher risk of metastases.[1] Skin SCC is found more frequently in men (M:F 3:1) and the incidence increases significantly after the age of 60. Risk factors for the development of SCC are: cumulative sun exposure, chemicals (arsenic), HPV, smoking, freckles, red hair, xeroderma pigmentosum, oculocutaneous albinism, EDV, dystrophic EB, chronic non healing wound, porokeratosis, organ transplant and AIDS patients with HPV infection. Clinically, there may be SCC *in situ* or invasive SCC.[3] Invasive perianal SCC is a locally infiltrative malignant skin tumor that exhibits destructive growth. It is a relatively uncommon tumor, which develops from the precursor lesion i.e. anal intraepithelial neoplasia (AIN).[2] Anal and perianal SCC is associated with persistent high-risk HPV infection, previous lower genital tract dysplasia/ carcinoma, high-frequency anoreceptive intercourse, heavy cigarette smoking and immunosuppression.[4] Not all perianal SCCs or condylomas are associated with HPV infection. Anal margin lesions refer to tumors starting at the distal end of the anal canal to a 5cm margin surrounding the anal verge. The staging of anal marginal cancers by the American joint committee is as follows: T1 if the tumor is <2 cm in size, T2 if it is 2-5 cm, T3 if it is >5 cm, and T4 signifies invasion of deep extradermal structures, such as bone, nerve, striated muscle, or cartilage. N0 and N1 refer to no regional and regional lymph node spread respectively.[5]

Wide local excision alone is appropriate for T1 and early T2 lesions that can be excised with a 1 cm margin. However, larger cancers usually should be treated with the addition of prophylactic radiation to the inguinal lymph nodes along with radiation or excision of the primary tumor. For T3 and T4 lesions, radiation to both inguinal regions and the pelvis, along with chemotherapy, such as 5-FU and mitomycin C or cisplatin, usually should be added. Abdominoperineal resection is most appropriate for patients who are already incontinent with large, bulky tumors extending into the sphincter muscle.[6]

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